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HEMI-SYNC® IN MY PSYCHIATRIC PRACTICE

by Jonathan H. Holt, MD

Jonathan H. Holt, MD, graduated from Yale University in 1980 and received Yale's Lidz Prize in psychiatry. Dr. Holt also did his residency at Yale and completed a fellowship in consultation-liaison psychiatry (medical psychiatry) at Mt. Sinai Medical Center in New York. He is on the clinical faculty at Albany Medical College and is on staff as consultation-liaison psychiatrist at St. Peter's Hospital in Albany, New York. Jon is a third-level Reiki practitioner and a practitioner of therapeutic touch and other subtle energy methods. He also utilizes eye movement desensitization reprocessing (EMDR), thought field therapy (TFT), and EEG and peripheral biofeedback. He has been a member of The Monroe Institute Professional Division since 1996.

An interest in exploring consciousness long predated my psychiatry career and was partially responsible for my choice of profession. I decided on an eclectic training program at Yale University and subspecialized in consultation-liaison psychiatry—sometimes known as medical psychiatry. In that subspecialty one consults with patients under treatment for various medical problems about their coexisting psychological problems and psychiatric disorders. During my tenure as program director of consultation-liaison psychiatry at the Veterans Administration Medical Center in Albany, New York, I joined the Professional Division of The Monroe Institute and started to integrate Hemi-Sync into my psychiatry practice.

When shrinking funding resulted in toxic organizational politics, I left the Veterans Administration and affiliated with two private practice groups. This allowed me to specialize in outpatient medical psychiatry and conduct a general psychiatric outpatient practice as well. I hoped to combine standard psychiatry techniques, e.g., psychopharmacology and generic psychotherapy, with less traditional therapies: Hemi-Sync, EMDR, TFT, peripheral and EEG biofeedback, subtle energy treatments, psychospirituality, and transpersonal psychiatry. After about one and a half years of private practice, a local hospital offered me an inpatient consultation-liaison psychiatry position, which opened up two somewhat different arenas of play.

In my consultation work I can be called in to evaluate any patient admitted to St. Peter's Hospital in Albany. These patients may be under the care of any internal medicine subspecialty: surgery, obstetrics and gynecology, neurology, rehabilitation medicine, hospice, or the substance abuse detoxification unit. Since there is no inpatient psychiatry unit in the hospital, all patients requiring concomitant medical and psychiatric care must be treated on one of the medical units. Once their medical conditions are stabilized, they are transferred to psychiatric hospitals if inpatient psychiatric treatment is indicated. Patients requiring, or to be

more accurate, accepting of or eligible for residential substance abuse rehabilitation programs are transferred elsewhere. The patient's personal physician, also termed the "attending," is the primary initiator of psychiatry consults. Prompting by the nursing or social work staff often plays a part in the physician's decision. Occasionally, patients will request consultation themselves. Thus urgent, if not dire, psychiatric conditions or perceptions of a problem that would benefit from psychiatric care determine which cases I will see.

In almost every instance involving agitation, anxiety, or depression, I offer Hemi-Sync tapes. My two standbys are *Surf* and *Cloudscapes*. *Surf* is the only Hemi-Sync audiotape with nature sounds. Incidentally, the *Stream Songs* relaxation video is wonderful, as is the rainstorm on the *Lucid Dreaming* album. *Cloudscapes* offers a gentle, neutral background that is comparable to nature sounds. A few people request tapes with verbal guidance. In such cases, *Guide to Serenity* and *Deep 10 Relaxation* have been very useful. *Pain Control* obviously has good hospital applicability. Administration of the tapes is an important technical consideration. Some patients have their own Walkman®. Sometimes a loan can be made from a hospital source, usually in the form of a boombox. The hospice unit is excellent in this regard because each room has one. Most commonly, however, a friend or relative is asked to bring a tape player. In a day or two it finally arrives—hopefully before the patient goes home! The hospital reimburses me for the tapes and presumably passes the charge along to the patients or their insurance.

Turnaround time in hospitals is generally quick nowadays. However, the readmission rate is climbing rapidly. Speedy turnover means limited feedback. This scenario is particularly true in the detoxification unit. Unless patients manifest severe withdrawal, they are often discharged within twenty-three hours. The more seriously incapacitated are usually discharged shortly after they become clear enough to process what I'm saying. In those circumstances I'm launching my assistance out into the void—a twenty-first century version of casting bread upon the waters. Despite the suboptimal conditions, I still try to discuss psychospirituality with most of my detoxification consults and offer Hemi-Sync tapes, where and when they are likely to be accepted. My negotiations with the substance abuse treatment department have focused on expanding the availability of Hemi-Sync and other complementary modalities.

On rare occasions, I receive feedback from hospital units with rapid turnaround. This clinical case is a good example.

Case 1: Surgery and Gastrointestinal (GI)

An eighteen-year-old woman with a family history of cholelithiasis (gallstones) presented at her college infirmary with acute upper abdominal pain and fever. She was examined, sent home, and received further diagnostic studies. She was diagnosed with cholelithiasis and an endoscopic retrograde cholangio-pancreatography (e.r.c.p.) was performed to remove the

stones. A cholecystectomy was planned but was postponed because the e.r.c.p. had induced pancreatitis. I gave her the *Pain Control* and *Surf* tapes with directions for using them, plus some positive imagery exercises. In addition, I performed subtle energy healing (combining techniques from Reiki, therapeutic touch, Barbara Brennan, and the *Dolphin Energy Club*). The patient and her mother were also instructed in a simple Huna-based healing exercise. The patient was discharged the next day and the cholecystectomy was scheduled for the following week. She later wrote me a letter saying that the techniques were effective for both the pancreatitis and the subsequent surgery and recovery.

Two settings maximize my chances for more extended interaction and better feedback: the medical rehabilitation unit and the hospice unit. Both units screen referrals from the rest of the hospital and from outside sources and are technically separate from other inpatient treatments. Stays in the rehabilitation unit tend to be shorter than in the hospice unit. Rehabilitation receives orthopedic patients, cardiac and cardiac surgery patients, and some neurological patients dealing with conditions like poststroke, multiple sclerosis, and amyotrophic lateral sclerosis.

Case 2: Rehabilitation Medicine

Mrs. A., a seventy-year-old widow, was first hospitalized after an overdose of sleeping medication in December 1999. I performed her psychiatric evaluation in the Intensive Care Unit. Upon stabilization, she was transferred to a nearby psychiatric hospital. In addition to depression and suicide attempts, Mrs. A. had abused pain medication for some time, which had resulted in a chronic organic brain syndrome (o.b.s.). After being weaned from the analgesics and antianxiety medications and cleared from her o.b.s., she had spinal surgery and then was transferred to rehabilitation. Depression, anxiety, and persistent GI symptoms complicated her recovery. Antidepressants helped Mrs. A.'s depression, but her anxiety persisted. There was a suspicion that the GI symptoms were psychosomatic. The detrimental effect of past substance abuse on her cognition ruled out conventional antianxiety medication. I prescribed *Surf* and *Guide to Serenity*. The patient played the tapes for several hours at a time and reported feeling much calmer while listening. She had some return of anxiety afterward. With repeated playing of the tapes, her general anxiety level improved markedly from her pretreatment state. Her physical and occupational therapy performance also improved. The GI symptoms did not change in response to the tapes, indicating the strong possibility of a nonpsychosomatic component. The patient was discharged to home after a week and a half.

The Hospice Inn, St. Peter's inpatient hospice setting, has been the most receptive to complementary interventions. It is also the inpatient unit with the longest stays.

Case 3: Hospice

An eighty-year-old widow, Mrs. G., had lost her husband to cancer seven months before admission. She had multiple medical problems, and an occult malignancy was suspected. She had been hospitalized due to acute shortness of breath and was found to have a pleural effusion. As her condition worsened, a pulmonary embolism was feared. Mrs. G. was anxious and depressed. After an extensive interview, I mentioned the possibility of using Hemi-Sync tapes for relaxation, as well as the *Going Home*® series. We talked about her fear of dying and her uncertain beliefs about death and the afterlife. As I described *Going Home*, the collaboration with Elisabeth Kübler-Ross, and related topics like near-death experiences (NDEs), she remembered a crucial bit of information. Many decades earlier, complications during labor and the delivery of her second child had caused cardiac arrest. Mrs. G. then had an NDE that included an out-of-body component and a visit "in the light." Listening to her story gave me an opportunity to support that memory and suggest that she return in her mind to the sensations of the NDE while listening to *Cloudscapes*. I promised to bring the *Going Home* tapes later. However, Mrs. G. died peacefully the next day.

Case 4: Hospice

Mrs. K., a fifty-four-year-old woman with advanced breast cancer, was also admitted to the Inn from the home hospice program. She had completed a significant number of life tasks and repeatedly told hospice staff that she was ready to go. She soon lapsed into a light coma but had persisted for several weeks in more or less the same state. Two visitors were present as we reviewed her case in a team meeting. One of them was a freelance writer doing an article on hospice for a local newspaper; the other was a representative of the hospital's public relations department. I raised the question of unfinished business and the possibility that she was being held back by some fear-based belief. The public relations representative wondered why I wanted to rush her if she wasn't suffering. I replied that I had no preference about her timing, but what if she was suffering quietly from fear? After a brief explanation of *Going Home*, the freelance writer volunteered that her grandmother had had an NDE. The nursing coordinator requested suggestions, and I offered one of the later *Going Home* tapes. The nurse coordinator called me later that same day to say that she had played *Homecoming* for the patient. Mrs. K.'s breathing had quieted and, by the end of the tape, she had peacefully expired.

Case 5: Hospice

Mrs. L., a fifty-eight-year-old mother with grown children, had a diagnosis of advanced lung cancer when she was transferred from home hospice. She was in considerable pain and had been admitted in order to optimize pain management. It was soon clear that Mrs. L. and her family would need the Hospice Inn for an extended period. Mrs. L. was a practicing Catholic and a former nurse. She was also terrified of losing control. Several weeks elapsed before her family permitted the hospice team to request a psychiatric consult. On interviewing Mrs. L. and

the other family members, it became clear that she had clinical depression and intermittent delirium with paranoia. I suggested a mild antidepressant and a small amount of antipsychotic medication. The latter is fast acting and was particularly helpful. The success of that intervention led the patient, the family, and the personal physician to become more accepting of my involvement.

Mrs. L. had a complex and ambivalent attitude toward complementary therapy and spiritual issues. On the one hand she accepted Reiki and therapeutic touch from friends and caregivers; on the other hand, she focused on medication as the key to her treatment. She described herself as religious. Yet, when I asked her about her afterlife beliefs, she admitted to being very unsure and scared. I played several of the latter *Going Home* tapes and performed a mixture of subtle energy techniques as she listened. During that process, I perceived an internal component of the self in the process of clearing and readying for transition. However, residual parts and energies were still entangled. I left the *Going Home* tapes with Mrs. L.'s family, who eagerly welcomed them. Her husband feared that she was holding on for the anniversary of her diagnosis, a date that was more than a month away, and thus faced the prospect of much additional suffering. The day after the healing session, the patient remained unconscious while the tapes played. The next day (a Saturday) Mrs. L. had some periods of wakefulness and anxiety, but she passed away early that evening—with her family in attendance.

These and other successes inspire me to work and hope for more complete integration of psychiatric and psychological services into the hospital system. I am negotiating with the various services to make Hemi-Sync more readily available. Hospital television already has a relaxation channel. Current offerings could be expanded to include Hemi-Sync presentations and instruction in using a variety of Hemi-Sync tapes, as well as consciousness expansion methods. Both patients and their caregivers stand to benefit from a partnership between standard interventions and complementary resources.

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